NASSAU COUNTY DEPARTMENT OF HEALTH
Division of Public Health Laboratories
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CLINICAL MICROBIOLOGY REQUISITION FORM (NCPHL408-4A)

Patient (last, first) _____
Address (Street, City, State, Zip) _____
ID number _____ DOB (mm/dd/yyyy) _____ Sex (M/F) _____
Ethnicity: Hispanic/Latino □Yes □No
Race □ Amer Indian/Alaskan □ Asian □ Black/Afr Amer □ Hawaiian/Pac Islander □ White
(DOB, Sex, Ethnicity, and Race Required for GC/CT, Syphilis, and HIV Testing)

Physician/Submitter (last, first) _____
Facility _____ Phone Number _____
Address (Street, City, State, Zip) _____

Specimen Type (if other, please specify) _____
Body Source, if applicable (Be specific) _____
Date of Collection (mm/dd/yyyy) _____20___Time of Collection (hh:mm) _____AM/PM

TEST REQUEST

IMMUNOLOGY (Note specimen requirements below)

☐ Hepatitis A Total Antibody
☐ Hepatitis A IgM
☐ Hepatitis B Surface Antigen
☐ Hepatitis B Surface Antibody
☐ Hepatitis B Core Total Antibody
☐ Hepatitis B Core IgM
☐ Hepatitis C Ab

All hepatitis tests can be performed on one 10cc speckled-top tube

☐ Rubella IgG
☐ Rubella IgM
☐ Mumps IgG
☐ Measles IgG
☐ Measles IgM
☐ Varicella IgG

All viral serology tests can be performed on one 10cc speckled-top tube

☐ Syphilis (RPR/FTA) (*One 7 or 10cc tube*)

☐ Chlamydia/GC NAAT (*Urine or Swab*)
☐ CSF Syphilis (VDRL) (*>3ml CSF*)

☐ HIV -1/HIV-2 EIA Screen (*one 7 cc tube*)
☐ HIV-1 WB only (*One 7cc or 10cc tube or OraSure)*

For HIV testing, sign below to certify that informed consent was obtained.

Informed Consent for HIV testing has been obtained

BACTERIOLOGY

☐ Culture and Identification
(enter specimen type and source above)
☐ Susceptibility Testing (indicate drugs below)
☐ Isolate Identification
☐ Rule Out _____
Specify Genus/Species

MYCOBACTERIOLOGY (Check one per form)

☐ Culture and Identification (includes smear)
☐ Smear Only

☐ Quantiferon (*call for special blood collection tubes)*
For Quantiferon, complete the following questions
Reason for Quantiferon Test _____
On Anti-tuberculosis Therapy? Yes☐ No☐
PPD Status _____ If Pos, Year _____

PARASITOLOGY

☐ Parasite Exam

Comments:

For HIV, Rapid Test Device □ Pos □ Neg □ Not Used